
**ICPA Coordinator**

**Kay Edenburn**

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# FECA
# Federal Employees' Compensation Act

- **Provides compensation benefits to civilian employees and National Guard Technicians, both permanent and temporary of the U.S. federal government for disability due to traumatic injury or disease or illness in performance of duties**
- **Provides payment of benefits to dependents for work-related death of an employee as a result of traumatic injury or occupational disease/illness**

- **FECA provides exclusive remedy for work-related injury, disease, or death**


# DOL
# Department of Labor

- Administers OWCP for all federal agencies
- Accepts or denies claims
- Adjudicates all claims
- Provides for payment of claims


# ICPA Coordinator
## Injury Compensation Program Administrator

- Assists in submission of claims
- Acts as the liaison between employee, supervisor and the DOL
- Informs employees and supervisors of program benefits and requirements


# RESPONSIBILITIES
# Supervisors

- Contact ICPA immediately of injured employee and request CA-16 Authorized for Examination And/Or Treatment
- Complete and submit forms in timely manner through Electronic Data Interchange (EDI)
  - CA-1 and CA-2 within ten days of receipt
  - CA-7 within five days of receipt
- Encourage safe work habits and conditions and enforce safety regulations
- Advise employees on rights and responsibilities
- Encourage reporting of incidents
- Publicize the OWCP and employees' responsibilities under it
- Continue pay in traumatic injuries


# RESPONSIBILITIES
# Supervisors

- Assist employees in returning to work
- Represent the agency's interest
- Challenge questionable claims
- Keep in contact with employee
- Help manage compensation costs
- Coordinate return to work with doctor and accommodate "light duty" work when able
- Coordinate personnel actions with HRO
- Track Injured Employee's Medical Status and availability for work
- Investigate incidents; obtain statements; controvert questionable claims


# RESPONSIBILITIES
## Employees

- Observe health and safety regulations
- Report potential and actual health, safety, and fire hazards
- Report all injuries to supervisor
- Obtain medical status reports from physician(s)
- Provide medical provider with Claim Number
- Cooperate with light duty placement
- It is the claimant responsibility to monitor his/her own claim, just as he/she would if it were an insurance claim
- Check the status on their bills through ACS-Web Billing Process Portal


The **FIVE** provisions for filing a claim

- **EMPLOYMENT**
- **TIMELINESS**
- **PERFORMANCE OF DUTY**
- **FACT OF INJURY**
- **CAUSAL RELATIONSHIP**


The **FIVE** provisions for filing a claim

## EMPLOYMENT

Must be a Federal Technician at the time of injury

## TIMELINESS

Notice of injury/disease must be filed within statutory time (3 years from the date of incident or exposure, or the date of awareness of a work relationship


# The **FIVE** provisions for filing a claim

## PERFORMANCE OF DUTY

Must have been in performance of official duties at time of incident

### COVERED

- Industrial premises
- Performing assigned duties
- Engaged in activities which are reasonable incidents of employment
- TDY
- Physical Training

### NOT COVERED

- Horseplay/assault
- Recreational injuries
- Travel to and from work w/fixed place of employee and fixed hours of work is **NOT** covered


The **FIVE** provisions for filing a claim

## FACT OF INJURY

Must be able to identify the factors which caused in injury/disability

- FACTUAL – Did the employee experience the incident?
- MEDICAL – Does the employee have a diagnosed condition as a result of the incident?

## CAUSAL RELATIONSHIP

Must prove federal employment cause – based on medical evidence from a physician who performed examination or provided treatment

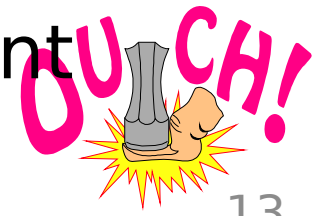

The **TWO** types of injuries

- **TRAUMATIC INJURY**
- **OCCUPATIONAL DISEASE/ILLINESS**

# TRAUMATIC INJURY

- A wound or other condition of the body caused by external force, including stress or strain.

- The injury must be identifiable by time and place of occurrence, and the member or function of body affected, and must be caused by a specific event or incident within a single day or work shift.



# OCCUPATIONAL DISEASE/ILLNESS

**A condition produced by -**

- systemic infections;
- continued or repeated stress or strain;
- exposure to toxins, poisons, fumes, etc.;
- other exposure to conditions of t work environment for two or more shifts.


# DOCUMENTATION
## For Traumatic Injury Cases:

- CA1 Federal Employee's Notice of Traumatic Injury and Claim for Continuation Pay/Compensation (electronically)
- CA 7 Claim for Compensation (electronically)
- CA 7aTime Analysis Form
- CA 7b Leave Buy Back Worksheet
- CA16 Authorization for Examination And/Or Treatment
- CA17 Duty Status Report
- CA 20 Attending Physician's Report
- CA 2 Notice of Recurrence


# DOCUMENTATION
## For Occupational Disease/Illness:

- CA2 Notice of Occupational Disease
- CA35 Series Specialized Occupational Disease Checklist
  (It is the employee responsibility to gather documentation)
- CA20 Attending Physician's Report
- CA2a


# OWCP Benefits

- Medical expenses (fee schedule)
- First aid expenses
- Rehabilitation
- Chiropractic care (limited)
  (manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist)
- Assisted Reemployment Program
  (Theraputic & Vocational Rehabilitation)


# OWCP Benefits (Con't)

- Early nurse intervention
- Continuation of Pay (COP)
- Compensation for Lost Wages
- Scheduled Benefits
- Permanent Total Disability
- Death Benefits


# CA Form 16

***This form is only available from your ICPA (Injury Compensation Program Administrator)***

## PURPOSE OF CA-16

Form CA-16 guarantees payment to the original treating physician (or any physician to whom the original treating physician refers the employee) for 60 days from date of issuance, unless OWCP terminates this authority at an earlier date.

## EMERGENCY

In an emergency, where there is no time to complete CA-16, The supervisor may authorize medical treatment verbally and then request CA-16 from ICPA within 48 hours. The supervisor will then forward the CA-16 and other documentation to the medical facility and provide the IPCA with completed documentation.

## NOT ALLOWED

Retroactive issuance of the CA-16 is not allowed under any other circumstance. Issuing of CA-16 if more than a week has passed since the injury, is not allowed.


**If it is a life or death situation**
**dial 911**
**for the Air National Guard base 117 or 911**

## Basic Information needed to issue CA Form 16

- Employee's Last Name, First Name, MI
- Date of injury
- Employee's Occupation
- Brief description of injury

I will then email approved CA Form 16 to include page 2 and CA Form 17 with all instructions (Supervisor's will insure that blocks 8 & 9 on page 1 of CA Form 16 are completed and given to employee).

If I am TDY or on vacation contact COL Burckle, MAJ Lock or Mr. Groves my District Manager.
or email: **NGUTHRO-HRS(OWCP)**


# Form CA-16 Packet

Authorization for Examination And/Or Treatment

**U.S. Department of Labor**
Employment Standards Administration
Office of Workers' Compensation Programs

The following request for information is authorized by law (5 USC 8101 et. seq.). Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and OMB Cir. No. A-108.

OMB No.: 1215-0103
Expires: 10-31-99

**PART A - AUTHORIZATION**

1. Name and Address of the Medical Facility or Physician Authorized to Provide the Medical Service:

| 2. Employee's Name (last, first, middle) | 3. Date of Injury (mo. day, yr.) | 4. Occupation |
|---|---|---|
| DOE, JOHN C. | 01/22/2011 | Surf Maint Coord |

5. Description of Injury or Disease
While playing basket ball an authorized physical activity, I jump for the ball and rolled left ankle

6. You are authorized to provide medical care for the employee for a period of up to sixty days from the date shown in item 11, subject to the condition stated in item A, and to the condition indicated either 1 or 2, in item B.

A. Your signature in item 35 of Part B certifies your agreement that all fees for services shall not exceed the maximum allowable fee established by OWCP and that payment by OWCP will be accepted as payment in full for said services.

B. ☐ 1. Furnish office and/or hospital treatment as medically necessary for the effects of this injury. Any surgery other than emergency must have prior OWCP approval.

☐ 2. There is doubt whether the employee's condition was caused by an injury sustained in the performance of duty, or is otherwise related to the employment. You are authorized to examine the employee using indicated non-surgical diagnostic studies, and promptly advise the undersigned whether you believe the condition is due to the alleged injury or to any circumstances of the employment. Additionally, whether advice you may provide necessary conservative treatment if you believe the condition may be to the injury or the employment.

| 7. If a Disease or Illness is Involved, Other Evidence for Issuing Authorization was Obtained from: (Type Name and Title of OWCP Official) | 8. Signature of Authorizing Official: |
|---|---|
| JANE M. DOE<br>IPCA Coordinator | 9. Name and Title of Authorizing Official (Type or print clearly) |
| 10. Local Employing Agency Telephone Number: | 11. Date (mo., day, year) |
| 801.432.4243 | 01/22/2011 |

12. Send one copy of your report: (Fill in remainder of address)

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs
DFEC Central Mailroom
P.O. Box 8300
London, KY 40742

13. Name and Address of Employee's Place of Employment:

Department of Agency
Utah National Guard (ARMY or AIR)
Bureau or Office
HRO-ICPA
Local Address (including ZIP Code)
Headquarters Utah National Guard
12953 South Minuteman Drive
Draper, UT 84020-1776

**Public Burden Statement**

We estimate that it will take an average of 30 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of IRM Policy, U.S. Department of Labor, Room N1301, 200 Constitution Avenue, N.W., Washington, D.C. 20210; and to the Office of Management and Budge [illegible]perwork Reduction Project (1215-0103), Washington, D.C. 20503.

DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES

Form CA-16
Rev. Oct. 1988

EXAMPLE

Supervisor's Signature
Supervisor's Title

14. Employee's Name (last, first, middle) DOE, JOHN C.

15. What History of Injury or Disease Did Employee Give You?

16. Is there any History or Evidence of Concurrent or Pre-existing Injury, Disease, or Physical Impairment? (If yes, please describe) ☐ Yes ☐ No — 16a. ICD-9 Code

17. What are Your Findings? (Include results of X-rays, laboratory tests, etc.) 18. What is Your Diagnosis? — 18a. ICD-9 Code

19. Do You Believe the Condition Found was Caused or Aggravated by the Employment Activity Described? (Please explain your answer if there is doubt) ☐ Yes ☐ No

20. Did Injury Require Hospitalization? ☐ Yes ☐ No
If yes, date of admission (mo., day, year)
Date of discharge (mo., day, year)

21. Is Additional Hospitalization Required? ☐ Yes ☐ No

22. Surgery (If any, describe type)

23. Date Surgery Performed (mo., day, year)

24. What (Other) Type of Treatment Did You Provide?

25. What Permanent Effects, if Any, Do You Anticipate?

26. Date of First Examination (mo., day, year) 27. Date(s) of Treatment (mo., day, year) [illegible]te of Discharge from Treatment (mo., day, year)

29. Period of Disability (mo., day, year) (If termination date unknown, indicate) 30. Employee Able to Resume
Total Disability: From To ☐ Light Work Date:
Partial Disability: From To ☐ Regular Work Date:

31. If Employee is Able to Resume Work, Has Employer Been Advised? ☐ Yes ☐ No If Yes, Furnish Date Advised

32. If Employee is Able to Resume Only Light Work, Indicate the Extent of Physical Limitations and the Type of Work that Could Reasonably be Performed with these Limitations.

33. General Remarks and Recommendations for Future Care, If Indicated. If you have made a Referral to Another Physician or to a Medical Facility, Provide Name and Address.

34. Do You Specialize? ☐ Yes ☐ No (If yes, state specialty)

35. SIGNATURE OF PHYSICIAN. I certify that all the statements in response to the questions asked in Part B of this form are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statement or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.

36. Address (No., Street, City, State, Zip Code)

37. Tax Identification Number 38. Date of Report

**Only a Medical Doctor (M.D.) signature is acceptable**

MEDICAL BILL: Charges for your services should be presented to the AMA standard "Health Insurance Claim Form" (AMA CP 407/408/409; OWCP-1500a, or HCFA 1500). Service must be itemized by Current Procedural Terminology Code (CPT 4) and the form must be signed.

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402

EXAMPLE


# Form CA-16 Packet (Con't)

Duty Status Report

Reset | Print

**U.S. Department of Labor**
Office of Workers' Compensation Programs

This form is provided for the purpose of obtaining a duty status report for the employee named below. This request does not constitute authorization for payment of medical expense by the Department of Labor, nor does it invalidate any previous authorization issued in this case. This request for information is authorized by law (5 USC 8101 et seq.) and is required to obtain or retain a benefit. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-108. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No. 1240-0046
Expires: 09-30-2011

OWCP File Number (If known)

**SIDE A - Supervisor:** Complete this side and refer to physician

1. Employee's Name (Last, first, middle): DOE JOHN C
2. Date of Injury (Month, day, yr.): 01/22/2011
3. Social Security No.: 123-45-6789
4. Occupation: SURFACE MAINTENANCE COORDINATOR
5. Describe How the Injury Occurred and State Parts of the Body Affected: While playing basketball a authorized Physical Activity, jumped and rolled right ankle.
6. The Employee Works: Hours Per Day 10.00 Days Per Week 4.00
7. Specify the Usual Work Requirements of the Employee. Check Whether Employee Performs These Tasks or Is Exposed Continuously or Intermittently, and Give Number of Hours.

| Activity | Continuous | Intermittent | |
|---|---|---|---|
| a. Lifting/Carrying: State Max Wt. | #lbs. | #lbs. | Hrs Per Day |
| b. Sitting | ☐ | ☐ | Hrs Per Day |
| c. Standing | ☐ | ☐ | Hrs Per Day |
| d. Walking | ☐ | ☐ | Hrs Per Day |
| e. Climbing | ☐ | ☐ | Hrs Per Day |
| f. Kneeling | ☐ | ☐ | Hrs Per Day |
| g. Bending/Stooping | ☐ | ☐ | Hrs Per Day |
| h. Twisting | ☐ | ☐ | Hrs Per Day |
| i. Pulling/Pushing | ☐ | ☐ | Hrs Per Day |
| j. Simple Grasping | ☐ | ☐ | Hrs Per Day |
| k. Fine Manipulation (Includes keyboarding) | ☐ | ☐ | Hrs Per Day |
| l. Reaching above Shoulder | ☐ | ☐ | Hrs Per Day |
| m. Driving a Vehicle (Specify) | ☐ | ☐ | Hrs Per Day |
| n. Operating Machinery (Specify) | ☐ | ☐ | Hrs Per Day |
| o. Temp. Extremes | ☐ | ☐ | range in degrees F |
| p. High Humidity | ☐ | ☐ | Hrs Per Day |
| q. Chemicals, Solvents, etc. (Identify) | ☐ | ☐ | Hrs Per Day |
| r. Fumes/Dust (Identify) | ☐ | ☐ | Hrs Per Day |
| s. Noise (Give dBA) | ☐ | ☐ | dBA Hrs Per Day |
| t. Other (Describe) | | | |

**SIDE B - Physician:** Complete this side

8. Does the History of Injury Given to You by the Employee Correspond to that Shown in Item 5? ☐ Yes ☐ No (If not, describe)
9. Description of Clinical Findings
10. Diagnosis Due to Injury
11. Other Disabling Conditions
12. Employee Advised to Resume Work? ☐ Yes, Date Advised ☐ No
13. Employee Able to Perform Regular Work Described on Side A? ☐ Yes, If so ☐ Full-Time or ☐ Part-Time Hrs Per Day ☐ No, If not, complete below:

| Activity | Continuous | Intermittent | |
|---|---|---|---|
| a. Lifting/Carrying: State Max Wt. | #lbs. | #lbs. | Hrs Per Day |
| b. Sitting | ☐ | ☐ | Hrs Per Day |
| c. Standing | ☐ | ☐ | Hrs Per Day |
| d. Walking | ☐ | ☐ | Hrs Per Day |
| e. Climbing | ☐ | ☐ | Hrs Per Day |
| f. Kneeling | ☐ | ☐ | Hrs Per Day |
| g. Bending/Stooping | ☐ | ☐ | Hrs Per Day |
| h. Twisting | ☐ | ☐ | Hrs Per Day |
| i. Pulling/Pushing | ☐ | ☐ | Hrs Per Day |
| j. Simple Grasping | ☐ | ☐ | Hrs Per Day |
| k. Fine Manipulation (Includes keyboarding) | ☐ | ☐ | Hrs Per Day |
| l. Reaching above Shoulder | ☐ | ☐ | Hrs Per Day |
| m. Driving a Vehicle (Specify) | ☐ | ☐ | Hrs Per Day |
| n. Operating Machinery (Specify) | ☐ | ☐ | Hrs Per Day |
| o. Temp. Extremes | ☐ | ☐ | range in degrees F |
| p. High Humidity | ☐ | ☐ | Hrs Per Day |
| q. Chemicals, Solvents, etc. (Identify) | ☐ | ☐ | Hrs Per Day |
| r. Fumes/Dust (Identify) | ☐ | ☐ | Hrs Per Day |
| s. Noise (Give dBA) | ☐ | ☐ | dBA Hrs Per Day |

14. Are Interpersonal Relations Affected Because of a Neuropsychiatric Condition? (e.g. Ability to Give or Take Supervision, Meet Deadlines, etc.) ☐ Yes ☐ No (Describe)
15. Date of Examination
16. Date of Next Appointment
17. Specialty
18. Tax Identification Number
19. Physician's Signature
20. Date

Form CA-17
Rev. Jan. 1997

EXAMPLE

## INSTRUCTIONS FOR AUTHORIZING OFFICIAL FOR COMPLETION OF PART A

**SELECTION OF PHYSICIAN**

- A Federal employee injured by accident while in the performance of duty has the initial right to select a physician of his/her choice to provide necessary treatment. The supervisor shall immediately authorize examination and appropriate medical care by use of Form CA-16 issued to either a United States medical officer/hospital or any duly qualified physician/ hospital of the employee's choice.

If the employee elects to be treated by a private physician, a copy of the American Medical Association standards billing form (AMA OP 407/408/409; OWCP-1500a) should be supplied together with Form CA-16.

A physician who is debarred from the FECA program as provided at 20 CFR 10.450-457 may not be authorized to examine or treat an injured Federal employee.

Generally, 25 miles from the place of injury, employing agency, or the employee's home is a reasonable distance to travel for medical care; however, other pertinent factors must also be considered.

**PERIOD OF AUTHORIZATION**

- Form CA-16 is valid for up to sixty days from date of issuance, and may be terminated earlier upon written notice from OWCP to the provider. It should not be used to authorize a change of physicians after the initial choice is exercised by the employee.

**FEDERAL MEDICAL FACILITIES**

- U.S. medical facilities include Public Health Service, Military, or VA hospitals. Federal health care facilities (health units) established under 5 USC 7901 are not U.S. medical facilities as used herein (see 20 CFR 10.400).

**DEFINITION OF INJURY**

- The term "injury" includes damage to or destruction of medical braces, artificial limbs and other prosthetic devices. Eyeglasses and hearing aids are included only if the damages were incidental to a personal injury which required medical services. Treatment for illness or disease should not be authorized unless approval is first obtained from OWCP.

**DEFINITION OF PHYSICIAN**

- The term "physician" includes doctors of medicine (MD), surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practitioners within the scope of their practice as defined by State law. The reimbursable services of chiropractors under the FECA are limited by statute to physical examination, related laboratory tests and X-rays to diagnose a subluxation of the spine; and treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by X-ray.

**FORM COMPLETION**

- Part A shall be completed in full by the authorizing official. The authorization is not valid unless the name and address of the physician or hospital is entered in item 1 and the signature of the authorizing official appears in Item B. Check B1 or B2 or Item 6, whichever is appropriate. In case of illness or disease, only Box B2 may be checked.

Show the address of the proper OWCP Office in item 12. Send original and one copy of Form CA-16 to the medical officer or physician. If issued for illness or disease, a copy must also be sent to OWCP.

**ADDITIONAL INFORMATION**

- See 20 CFR and/or Chapter 810, Federal Personnel Manual (FPM).

**Information for Physicians - See Reverse Side**

EXAMPLE


# Form CA-16 Packet (Con't)

INFORMATION FOR PHYSICIAN

**YOUR AUTHORIZATION**

- Please read Part A of Form CA-16. You are authorized to examine and provide treatment for the injury or disease described in Item 5, for a period of not more than 60 days from the date of issuance, subject to the conditions in Item 6. A physician who is debarred from the FECA program as provided at 20 CFR 10.450-457 may not be authorized to examine or treat an injured Federal employee. Authorization may be terminated earlier upon written notice from OWCP. For extension of the authorization to treat beyond the 60 day period, apply to the office shown in Part A, Item 12.

**USE OF CONSULTANTS AND HOSPITALS**

- You may utilize consultants, laboratories and local hospitals, if needed. Authorize semi-private accomodations unless a private room is medically necessary. Ancillary treatment may be provided to a hospitalized employee as necessary.

**REPORTS**

- After examination, complete items 14 through 38, of Part B, and send your report, together with any additional narrative or explanatory material, to the address listed in Part A, Item 12. If the employee sustained a traumatic injury and is disabled for work, reports on Form CA 17, "Duty Status Report" may be required from the employing agency during the first 45 days of disability. If disability continues beyond 45 days, monthly reports should be submitted. Reports from all consultants are required. Delay in submitting medical reports may delay payment of benefits.

**RELEASE OF RECORDS**

- Injury reports are confidential records of OWCP. They shall not be released to anyone nor may any copies be made of them without the approval of OWCP.

**BILLING FOR SERVICES**

- OWCP requires that charges be itemized using the AMA standard "Health Insurance Claim Form" (AMA CP 407/408/409; OWCP-1500, or HCFA-1500). Each procedure must be identified, in Column 24 C of the form, by the applicable Current Procedural Terminology (4th edition) Code CPT 4). A copy of the form may be supplid by the employee at the time treatment is sought.

- Payment for chiropractic services is limited to charges for physical examinations, related laboratory tests, and X-rays to diagnose a subluxation of the spine; and treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by X-ray.

**TAX IDENTIFICATION NUMBER**

- The provider's Tax Identification Number (TIN) is an important identifier in the OWCP system. To speed processing and to reduce inaccuracy of payment, the provider's TIN (Employer Identification Number or SSN) should be shown on all reports and billings submitted to OWCP. If possible, providers should decide on a single TIN - either corporate or personal - which is used consistently on OWCP claims.

**ADDITIONAL INFORMATION**

- Contact the OWCP shown in Item 12 of Part A.

**Please Remove These Instructions Before Submitting Your Report.**

EXAMPLE

State of Utah
UTAH NATIONAL GUARD

Gary R. Herbert
Governor
Major General Brian L. Tarbet
The Adjutant General

12953 MINUTEMAN DRIVE
DRAPER, UTAH 84020-9288
(801) 432-4400

28 March 2011

Human Resources Office

SUBJECT: Submission of Bills to Department of Labor

In the past, it has been the policy of the Department of Labor, Office of Workers' Compensation Program (OWCP), to have care providers submit their bills to the agency whose federal employee sustained an injury. Care providers may now submit bills to the London, KY address listed below. It is not necessary to go to the site for a care provider to register with the OWCP. Providers (excluding pharmacy) must bill with their ACS OWCP provider number in box 33 of HCFA or box 51 of UB-92. If the number is not on the form your bill will be returned. Prior approval for MRI's is no longer necessary, providing there is direct causal relationship to the work-related injury. For prior approval of surgery, please call (800) 21[illegible] (FAX) or (866) 335-8319. If the claim is denied by Department of Labor, please call them at the toll number (850) 558-1818. Often it is an error in **ICD9 coding**. Which should be obtained from the claimant, your **registration number** is missing, or the **claimant's claim number** was not included on the bill. Bills should also include **medical records relating to the injury** and a **copy of the CA-16**, which should be presented to you on the first visit (the original CA-16 should be returned to the individual). Please submit bills directly to the following:

**U.S. DEPARTMENT OF LABOR**
**DFEC CENTRAL MAILROOM**
**PO BOX 8300**
**LONDON KY 40742-8300**

Registration can be accomplished on-line at https://owcp.dol.acs-inc.com, or at **850-558-1818**, which will be a toll call. An OWCP case number must be on all submissions. This agency can provide the case number to you, as soon as it is available, which is normally within 10 working days after the injury.

You and your Care Provider can monitor bills at this site: **http://owcp.dol.acs-inc.com**

Right click and select open hyperlink

Agency
Claimant
Provider

EXAMPLE


## Form CA-16 Packet (Con't)

Return completed CA16 page 1 and 2
Completed CA 17 and any other documentation received from the Medical Provider to ICPA Coordinator as soon as possible

**REMINDER**

Only a Medical Doctor (M.D.) signature is acceptable on all medical documents


**Forms required for follow-up appointments**

## CA17 and CA20

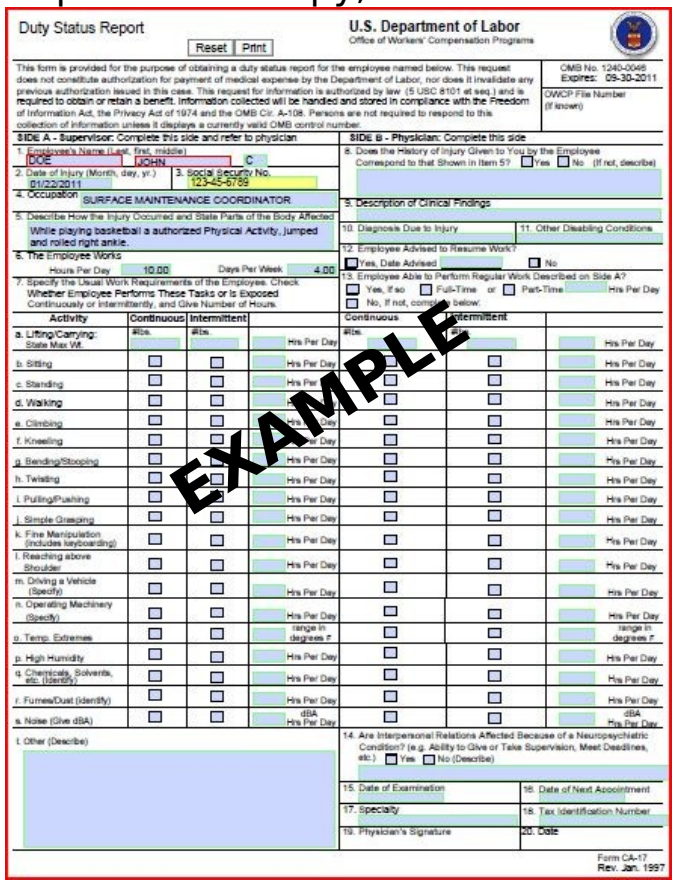
**The employee must ensure that he/she has the Medical Provider complete CA17 and CA20**

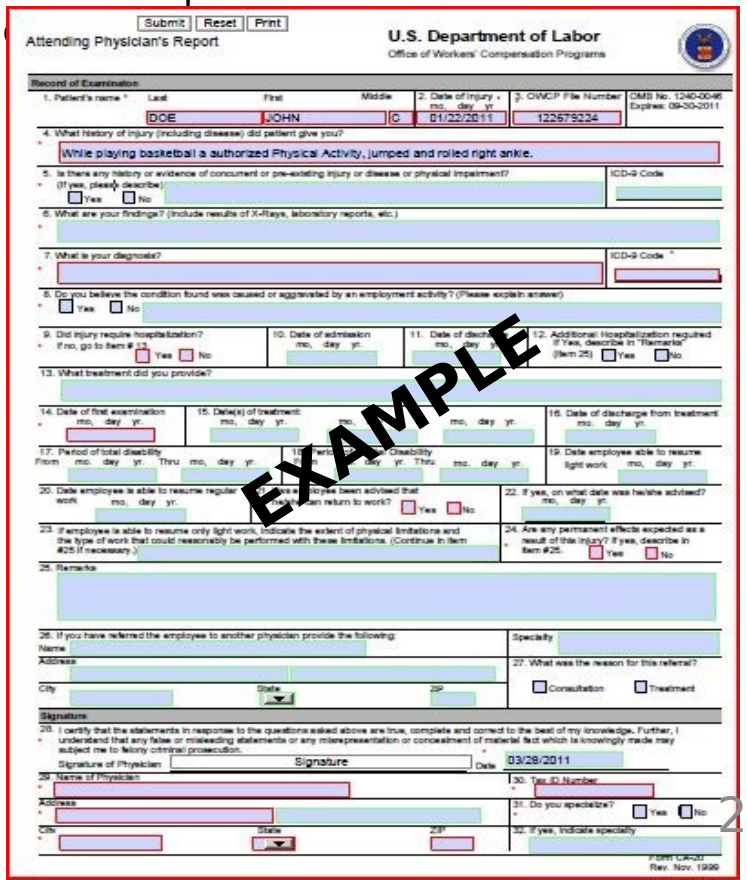
**REMINDER**

Only a Medical Doctor (M.D.) signature is acceptable on all medical documents


## FOLLOW-UP VISITS

If an employee requires follow up visits, his/she must have in there possession CA-17 and CA20. Medical provider must complete there portion (reminder only a Medical Doctor (MD) signature is acceptable) on the above documents. Ensure ICPA Coordinator is provided a copy, documentation will be forward to Department of Labor for further processin




# Filing Claims using Electronic Data Interchange

- DoD Civilian Personnel Management Service
- Injury and Unemployment Compensation Division


# EDI Electronic Data Interchange

- It has been DoD policy since July 2003 to utilize EDI when submitting claims
- DOL will be monitoring agency timeliness for claim submission as a result of POWER
- Defense Safety Oversight Council (DSOC) will be monitoring DoD agency timeliness and use of EDI for claim submission


# Safety First Electronic Reporting (SAFER)

- DOL has made a determination as to which claim data can be shared with an organization's safety office in order to assist in fulfilling OSHA reporting requirements

- EDI/SAFER provides the data to safety in the form of an OSHA 301 notice. This 301 notice provides safety with the data they need to *start* their reporting and investigations


# EDI INFORMATION FLOW

- Employee reports the injury to his/her supervisor
- Supervisor and employee complete the electronic form, which is transmitted to the ICPA. Supervisors do not need any special access to file the claim electronically, only a computer with internet access
- Supervisor prints completed CA1


# EDI INFORMATION FLOW

- Injured employee and supervisor sign the printed copy of CA1
- Supervisor electronically submits claim for processing
- ICPA receives an email notification of the claim submission
- IPCA will review and enters appropriate codes and corrects any errors. If there is an error a corrected copy of CA1 will be sent to supervisor and injured employee for


# EDI INFORMATION FLOW

- IPCA will then forward claim to OWCP
- IPCA will receive, via email, a copy of the OSHA 301 and forward to the appropriate Safety Office, injured employee and supervisor via email
- OWCP receives claim, validates data and submits data to District OWCP for a claim number assignment

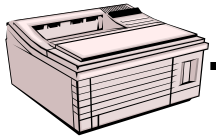

# EDI INFORMATION FLOW

- ICPA will receive an email with the claim number within 2-3 business days and provide the injured employee and supervisor the claim number via email
- It is the injured employee responsibility to provide the medical provider the claim number for billing purposes


# EDI – Electronic Data Interchange

Employee reports the injury to his/her supervisor

Supervisor and Employee complete the On-Line initiating claim form



Supervisor prints completed form **CA1**

Injured employee signs the printed copy for employee file

Supervisor electronically submits claim for processing

The ICPA is notified that a claim is awaiting authentication

ICPA reviews the claim for accuracy, enters appropriate codes, corrects any errors and authenticates the claim

IPCA receives OSHA 301 and forwards to Safety Supervisor and injured employee

Claim is forwarded to OWCP

OWCP receives claim, validates data, and submits data to District OWCP for case number assignment

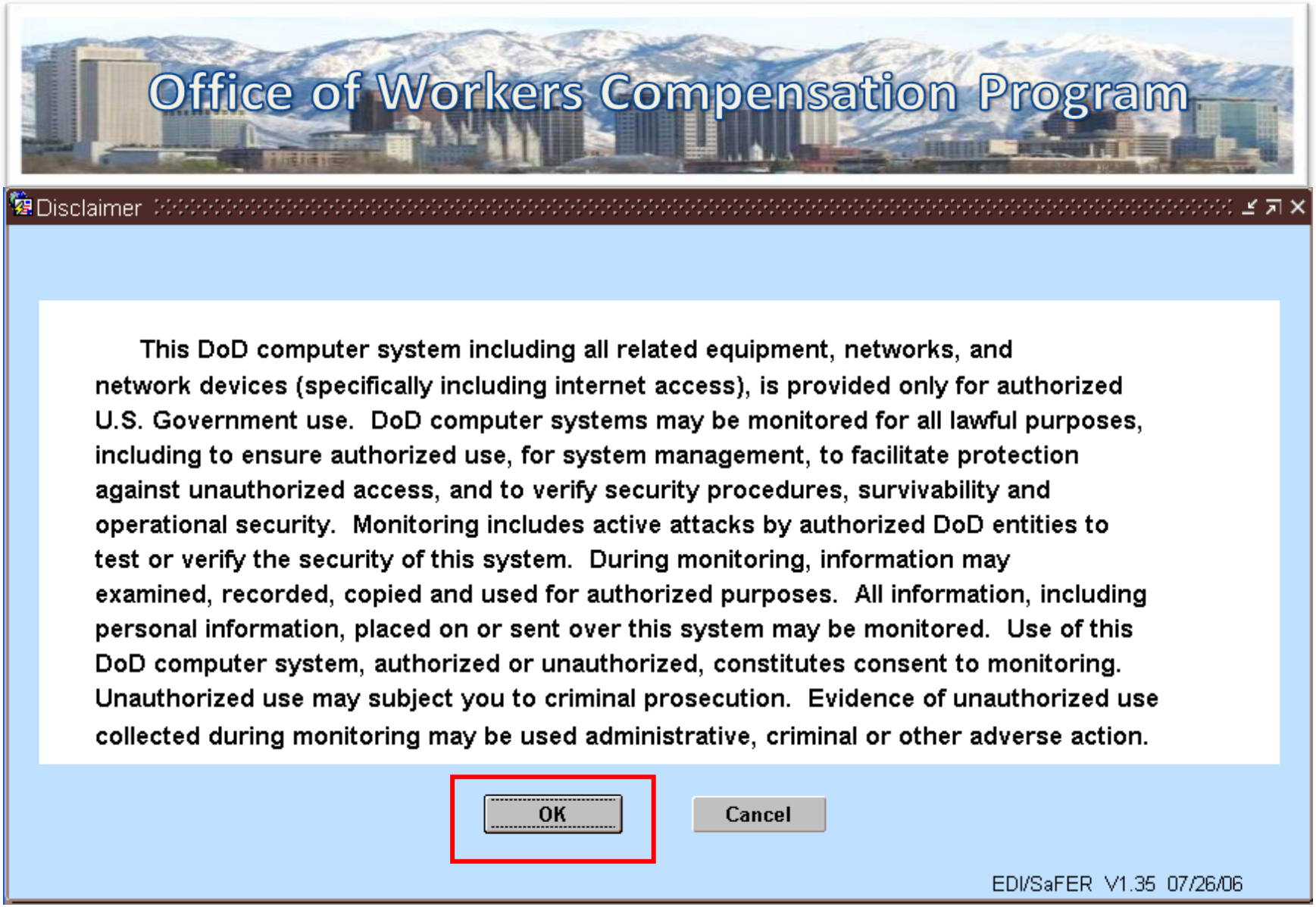
ICPA will receive claim number and forward to supervisor and injured employee via email


## On-line CA-1/CA-2

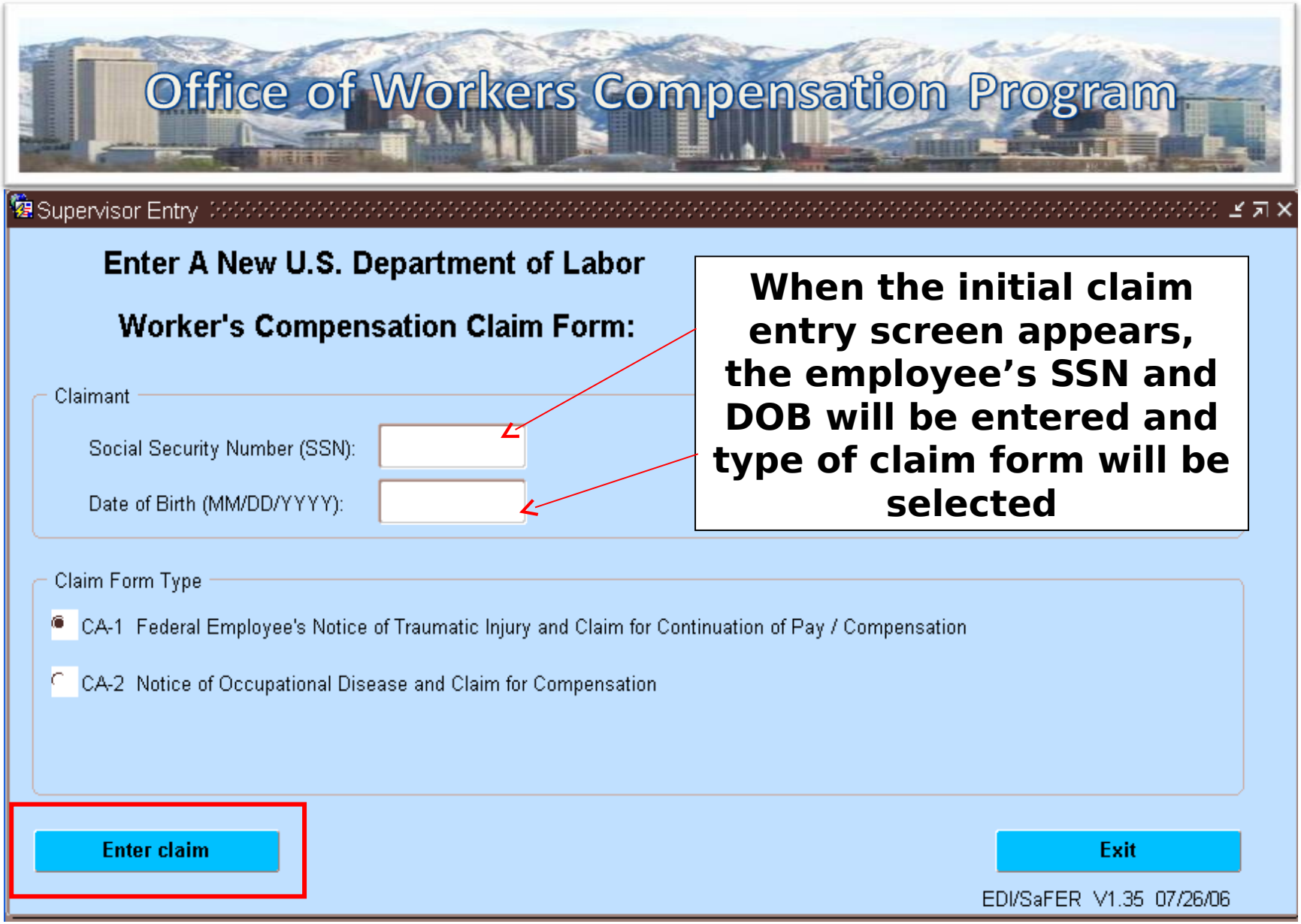
**NO hand written, typed or emailed CA-1 or CA-2 will be accepted**
**ALL CA-1 and CA-2 must be done electronically**

**http://www.cpms.osd.mil/icuc**

# Office of Workers Compensation Program

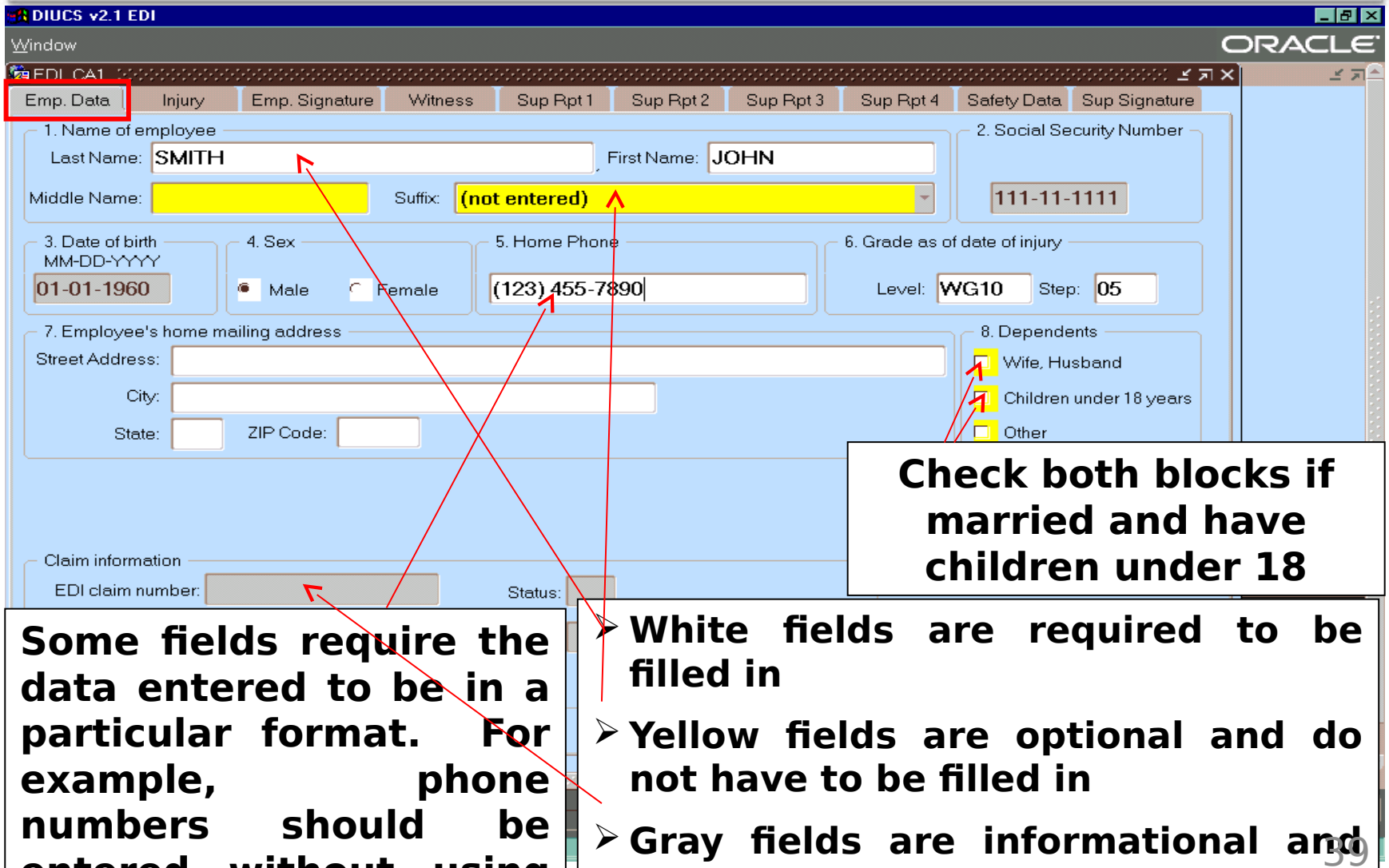



**Select OK in order to access the application**




**Select Enter Claim**

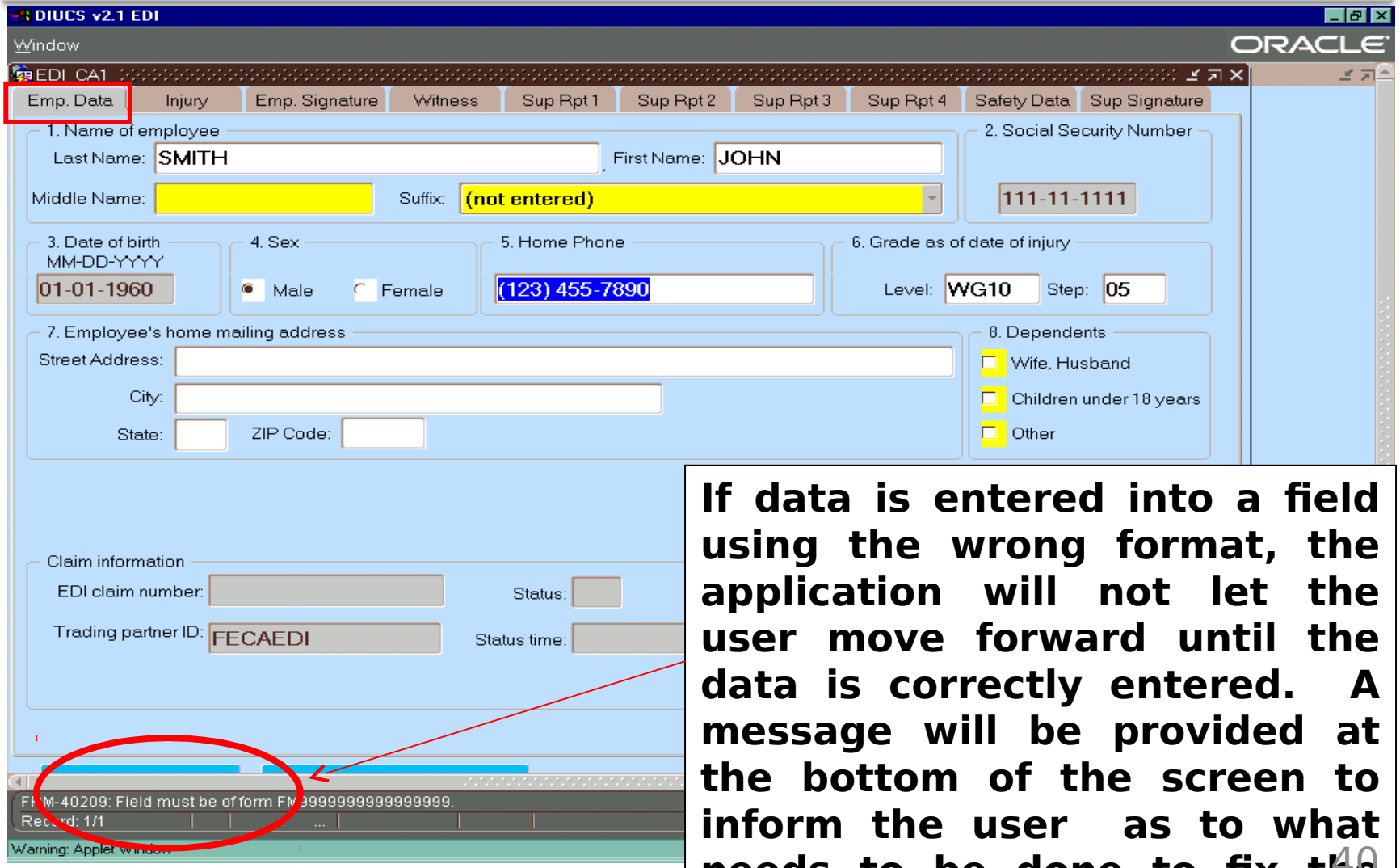
# Office of Workers Compensation Program




**Check both blocks if married and have children under 18**

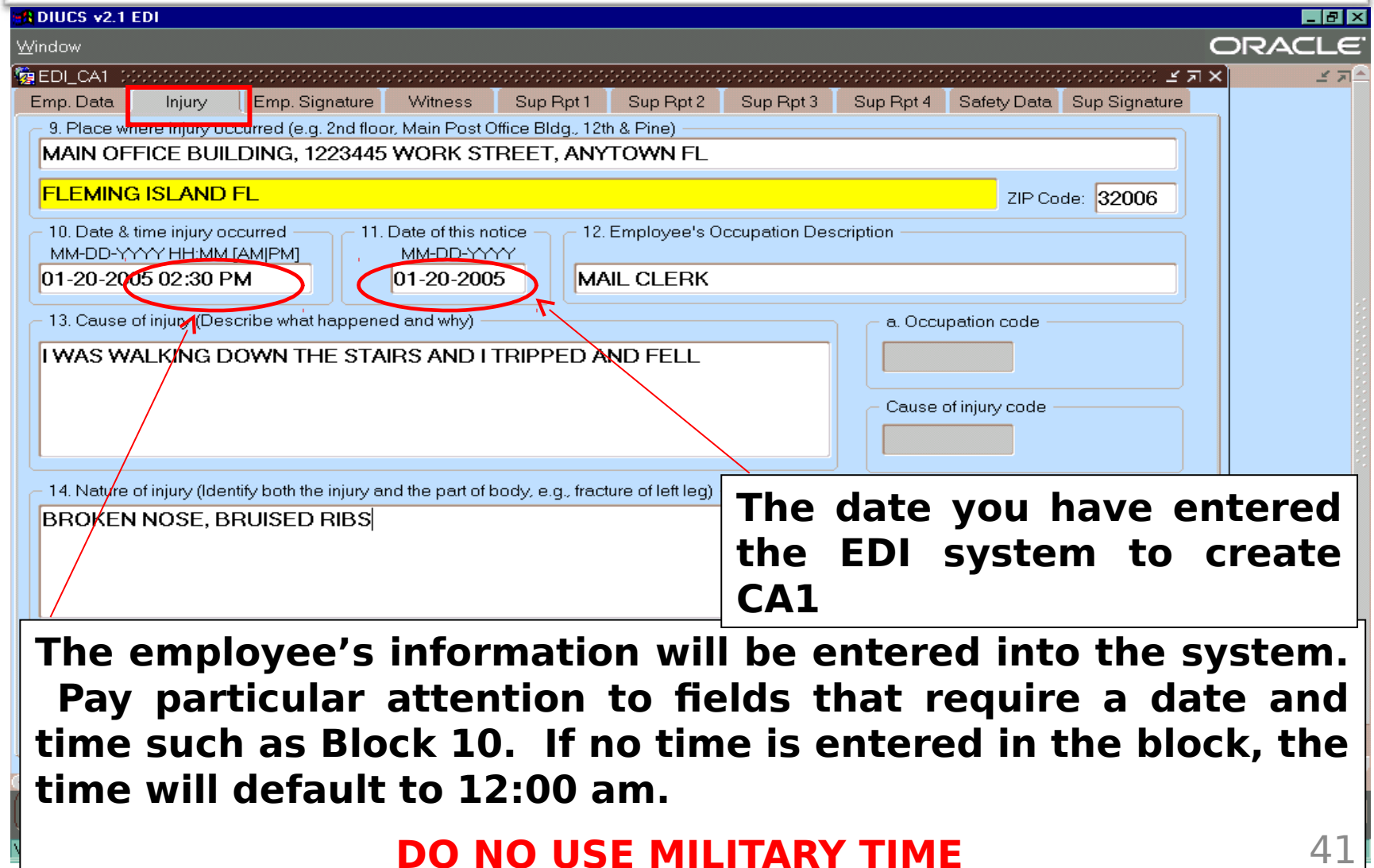
**Some fields require the data entered to be in a particular format. For example, phone numbers should be entered without using**

- **White fields are required to be filled in**
- **Yellow fields are optional and do not have to be filled in**
- **Gray fields are informational and cannot have data entered into**




**If data is entered into a field using the wrong format, the application will not let the user move forward until the data is correctly entered. A message will be provided at the bottom of the screen to inform the user as to what needs to be done to fix the**

# Office of Workers Compensation Program




**The date you have entered the EDI system to create CA1**

**The employee's information will be entered into the system. Pay particular attention to fields that require a date and time such as Block 10. If no time is entered in the block, the time will default to 12:00 am.**

**DO NO USE MILITARY TIME**


# Block 13 Cause of Injury

## NOT SO GOOD

- While walking between the maintenance shops, I slipped on an icy surface and fell backwards and landed on my back

## GOOD

- I as acquiring parts for the job order for the front end loader, I had to walk from the wash rack to the parts rack which is located outside the building. Due to snow and ice in and around the area I slipped and fell injuring my lower back


# Block 13 Cause of Injury

## NOT SO GOOD

- I was playing basketball and hurt my ankle

## GOOD

- I was playing basketball a authorized sport physical activity. I jumped for the ball and landed on someone else's foot and rolled my left ankle


# Block 14 Nature of Injury

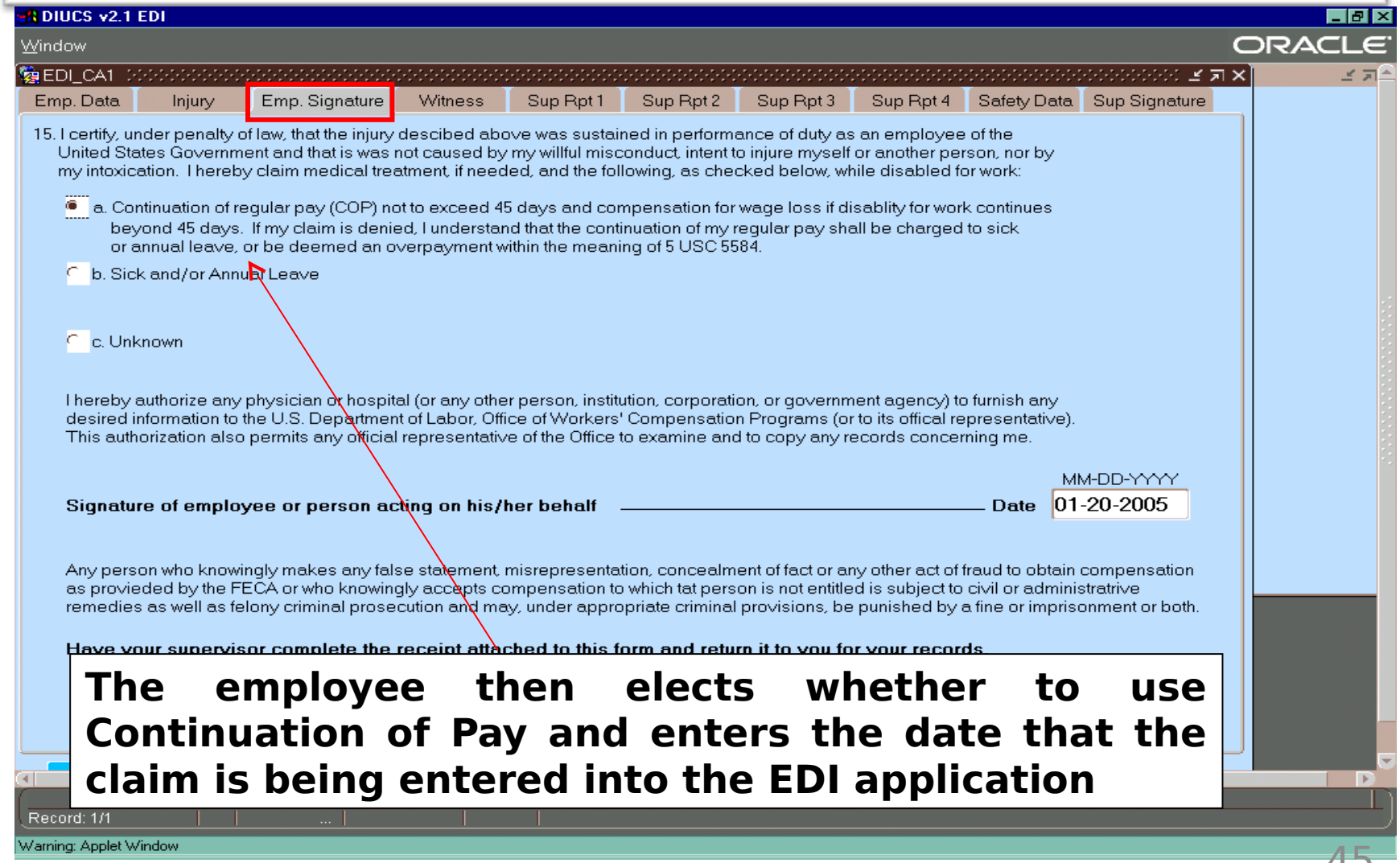
**NOT SO GOOD**

- Ankle
- Right finger
- Cut on head

**GOOD**

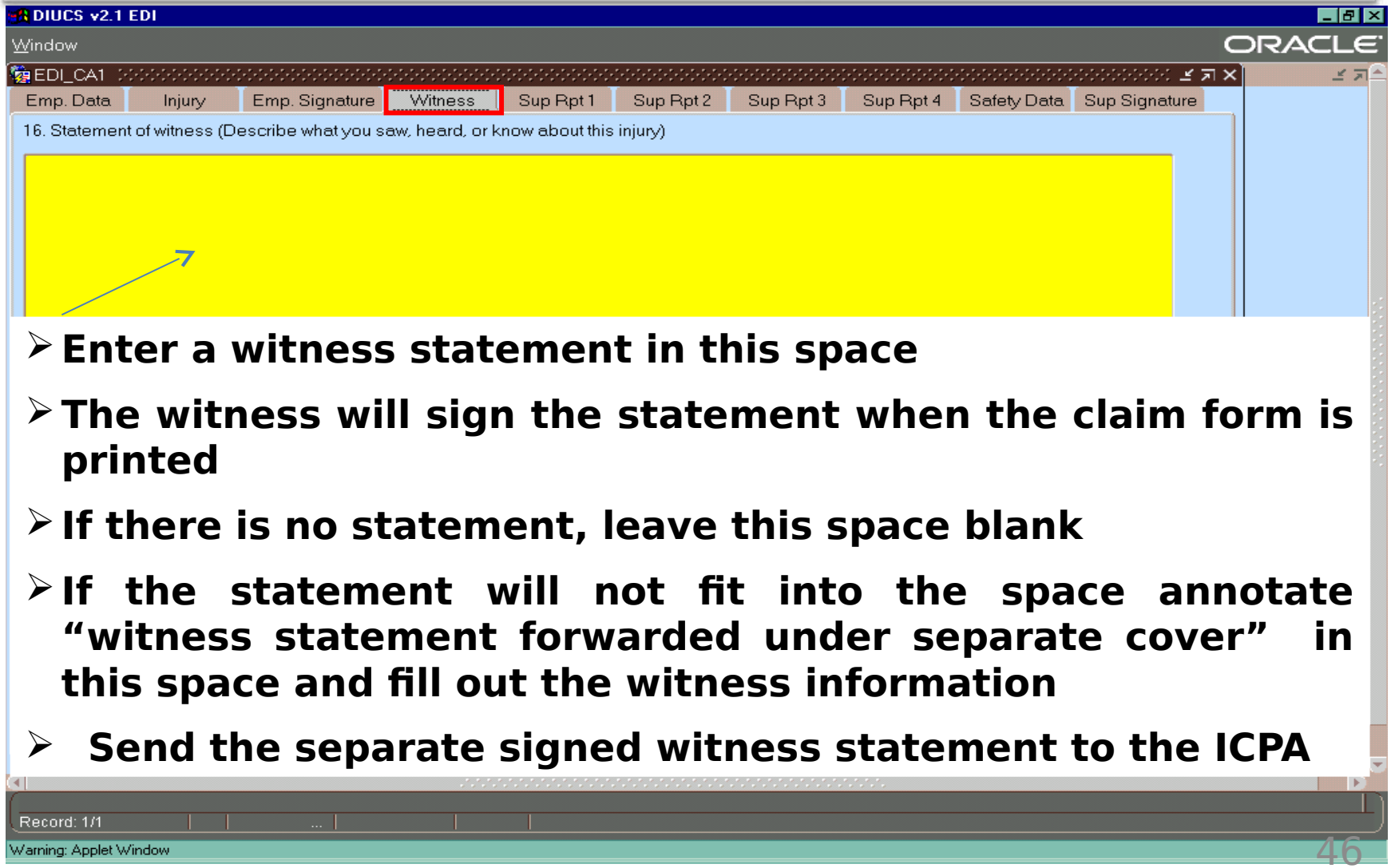
- Sprain right ankle
- Smashed right index finger
- Laceration on left side of head

# Office of Workers Compensation Program



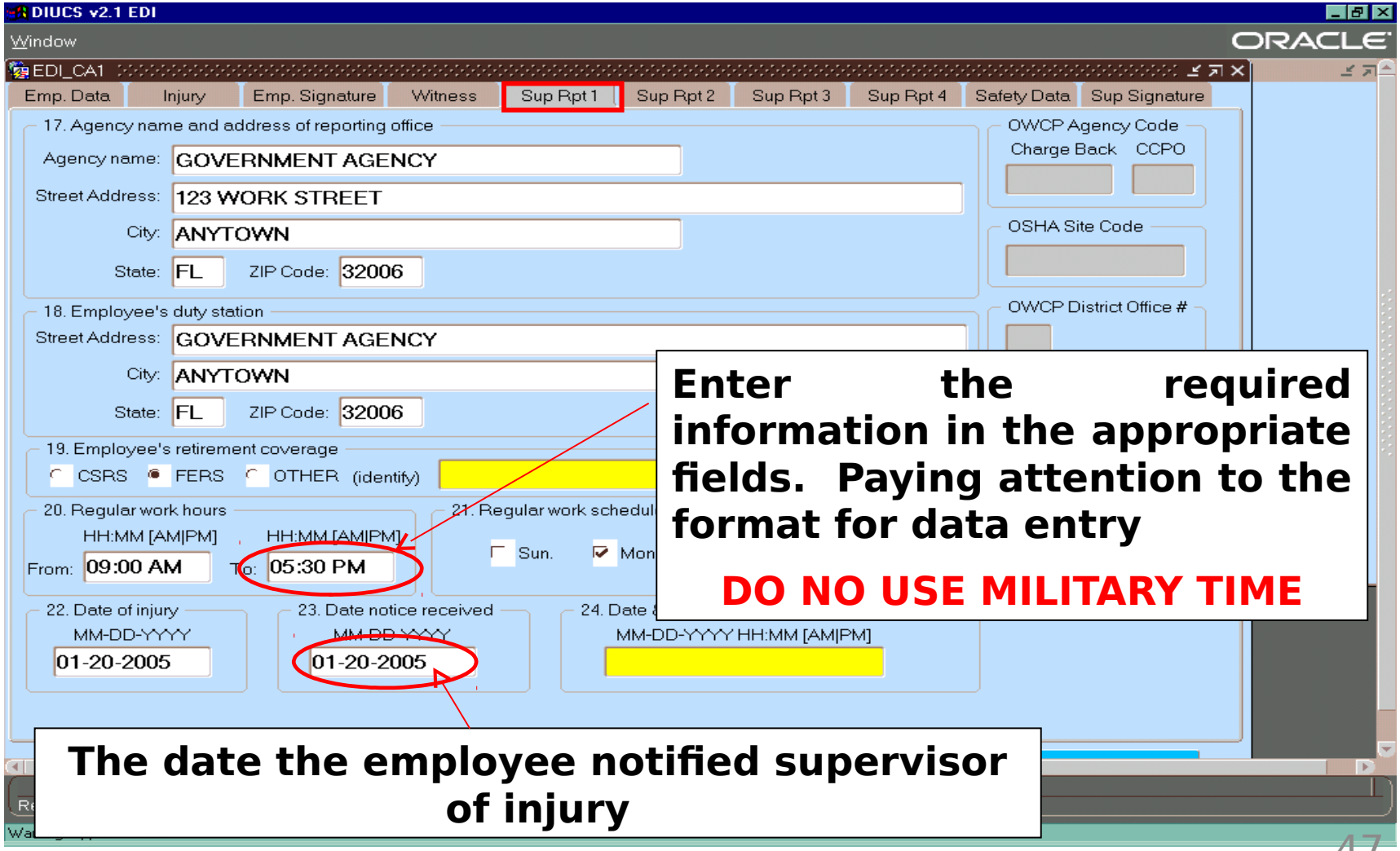

**The employee then elects whether to use Continuation of Pay and enters the date that the claim is being entered into the EDI application**

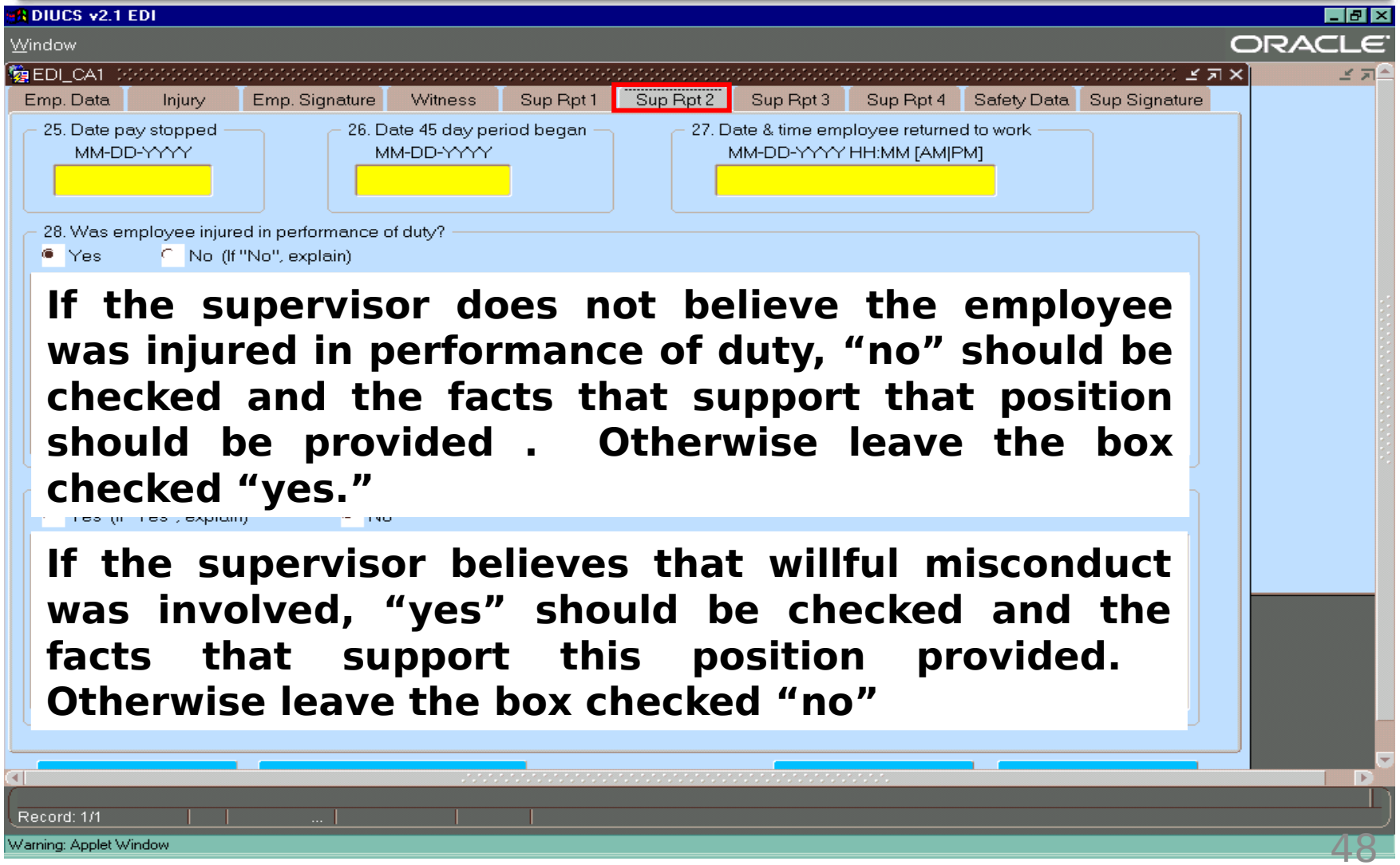
# Office of Workers Compensation Program



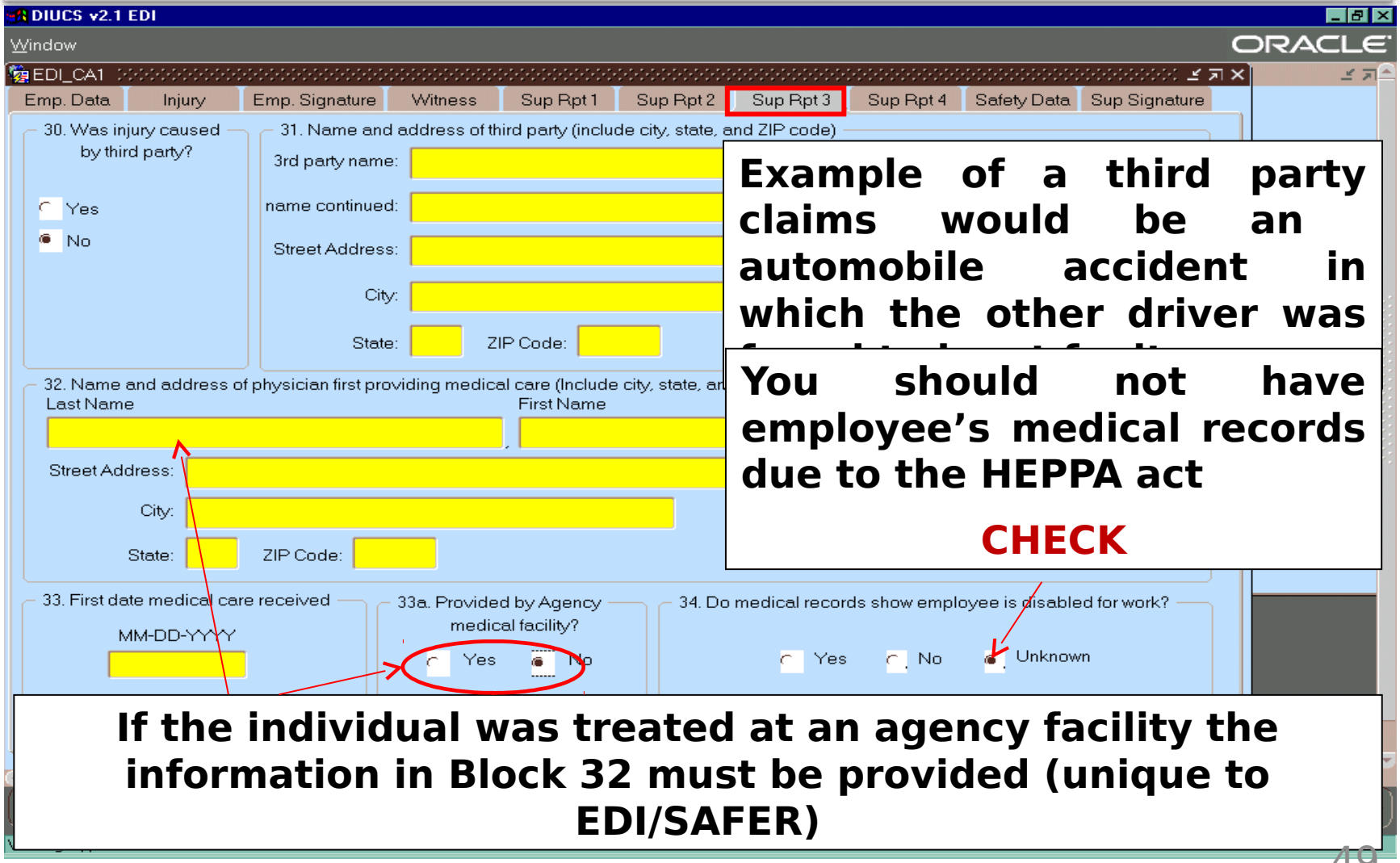

- **Enter a witness statement in this space**
- **The witness will sign the statement when the claim form is printed**
- **If there is no statement, leave this space blank**
- **If the statement will not fit into the space annotate "witness statement forwarded under separate cover" in this space and fill out the witness information**
- **Send the separate signed witness statement to the ICPA**

# Office of Workers Compensation Program




DIUCS v2.1 EDI
Window
ORACLE
EDI_CA1
Emp. Data
Injury
Emp. Signature
Witness
Sup Rpt 1
Sup Rpt 2
Sup Rpt 3
Sup Rpt 4
Safety Data
Sup Signature
25. Date pay stopped
MM-DD-YYYY
26. Date 45 day period began
MM-DD-YYYY
27. Date & time employee returned to work
MM-DD-YYYY HH:MM [AM|PM]
28. Was employee injured in performance of duty?
Yes
No (If "No", explain)
If the supervisor does not believe the employee was injured in performance of duty, "no" should be checked and the facts that support that position should be provided . Otherwise leave the box checked "yes."
If the supervisor believes that willful misconduct was involved, "yes" should be checked and the facts that support this position provided. Otherwise leave the box checked "no"
Record: 1/1
Warning: Applet Window

# Office of Workers Compensation Program



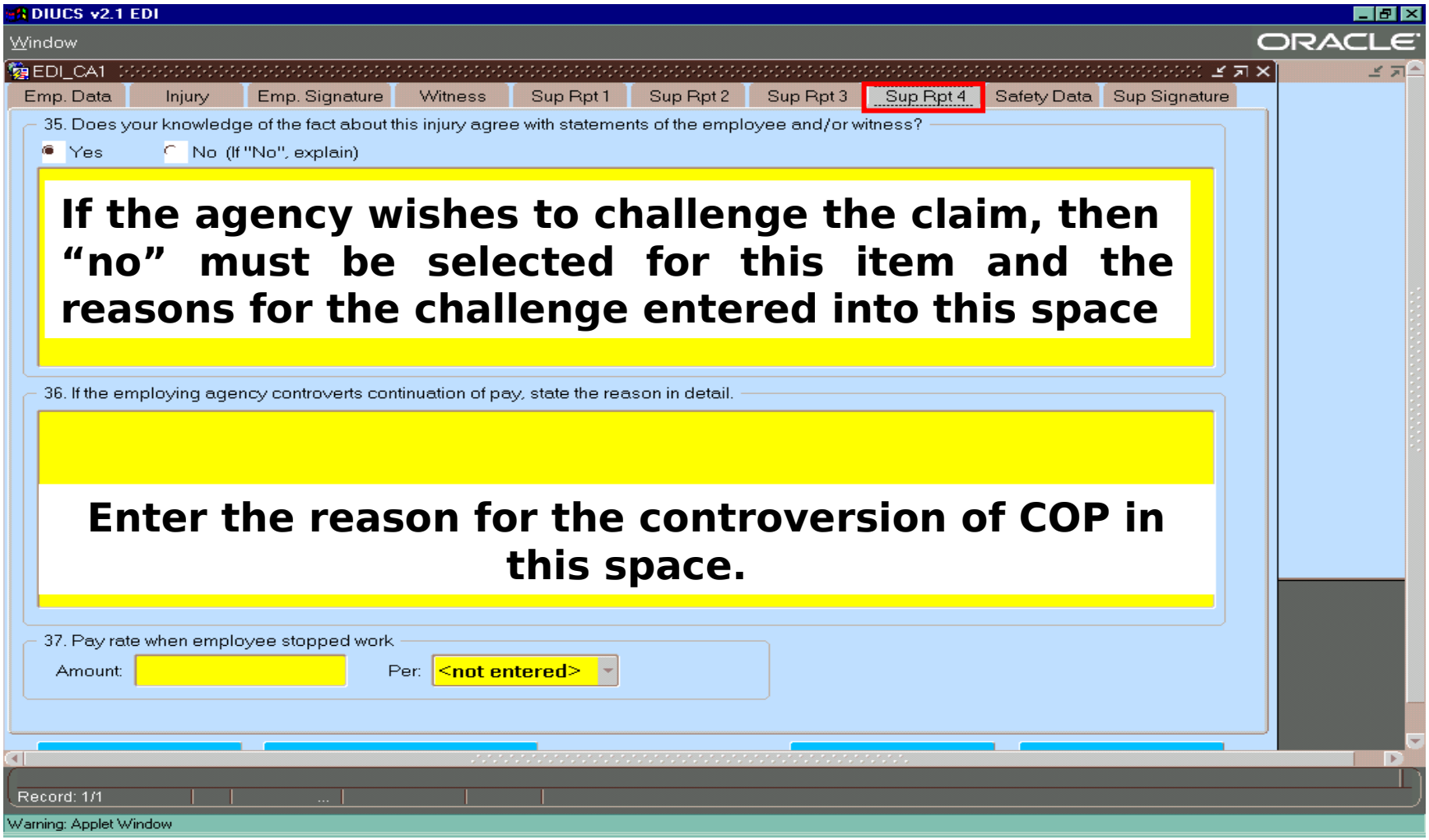

**Example of a third party claims would be an automobile accident in which the other driver was**

**You should not have employee's medical records due to the HEPPA act**

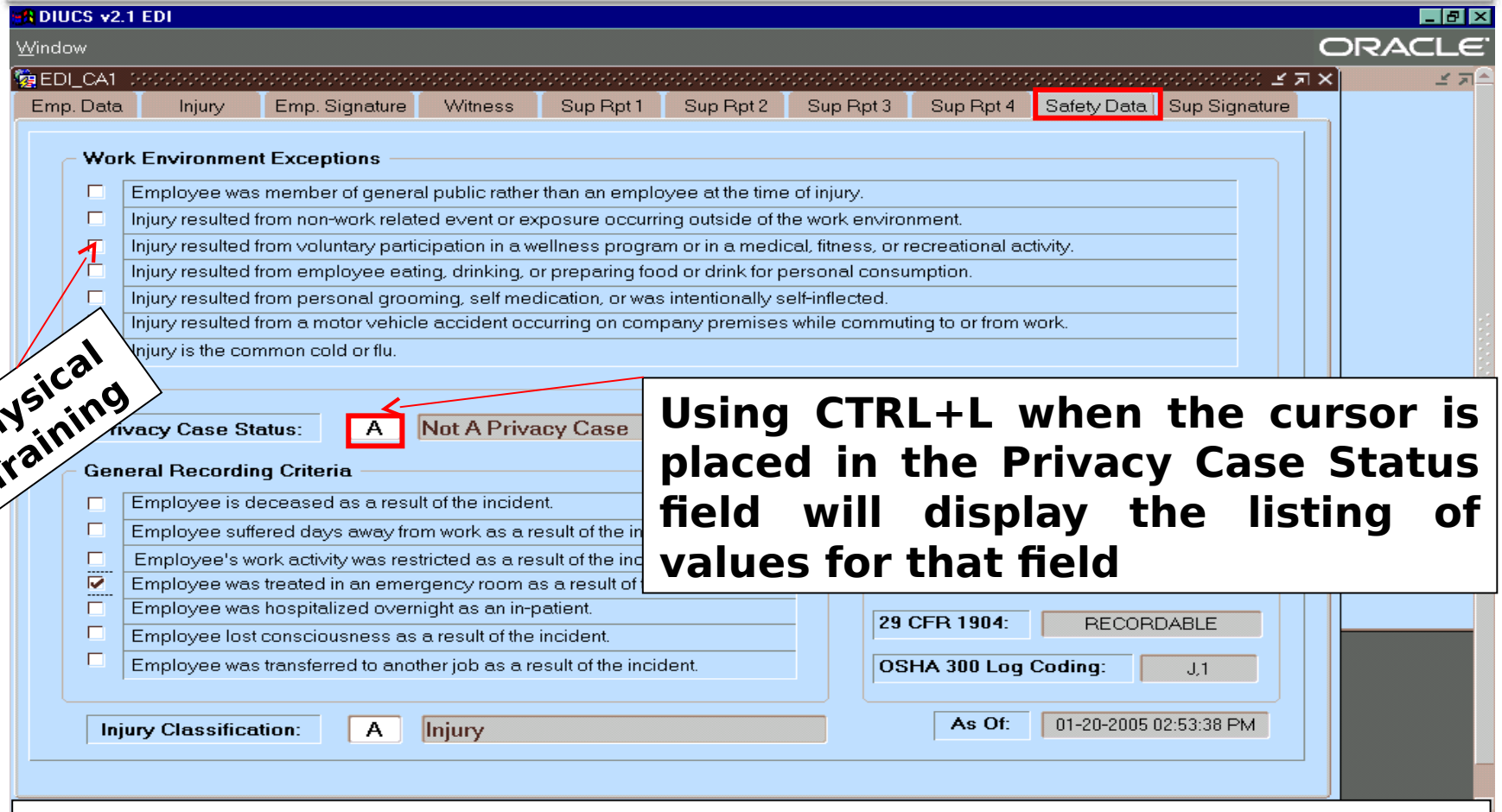
**CHECK**

**If the individual was treated at an agency facility the information in Block 32 must be provided (unique to EDI/SAFER)**

# Office of Workers Compensation Program



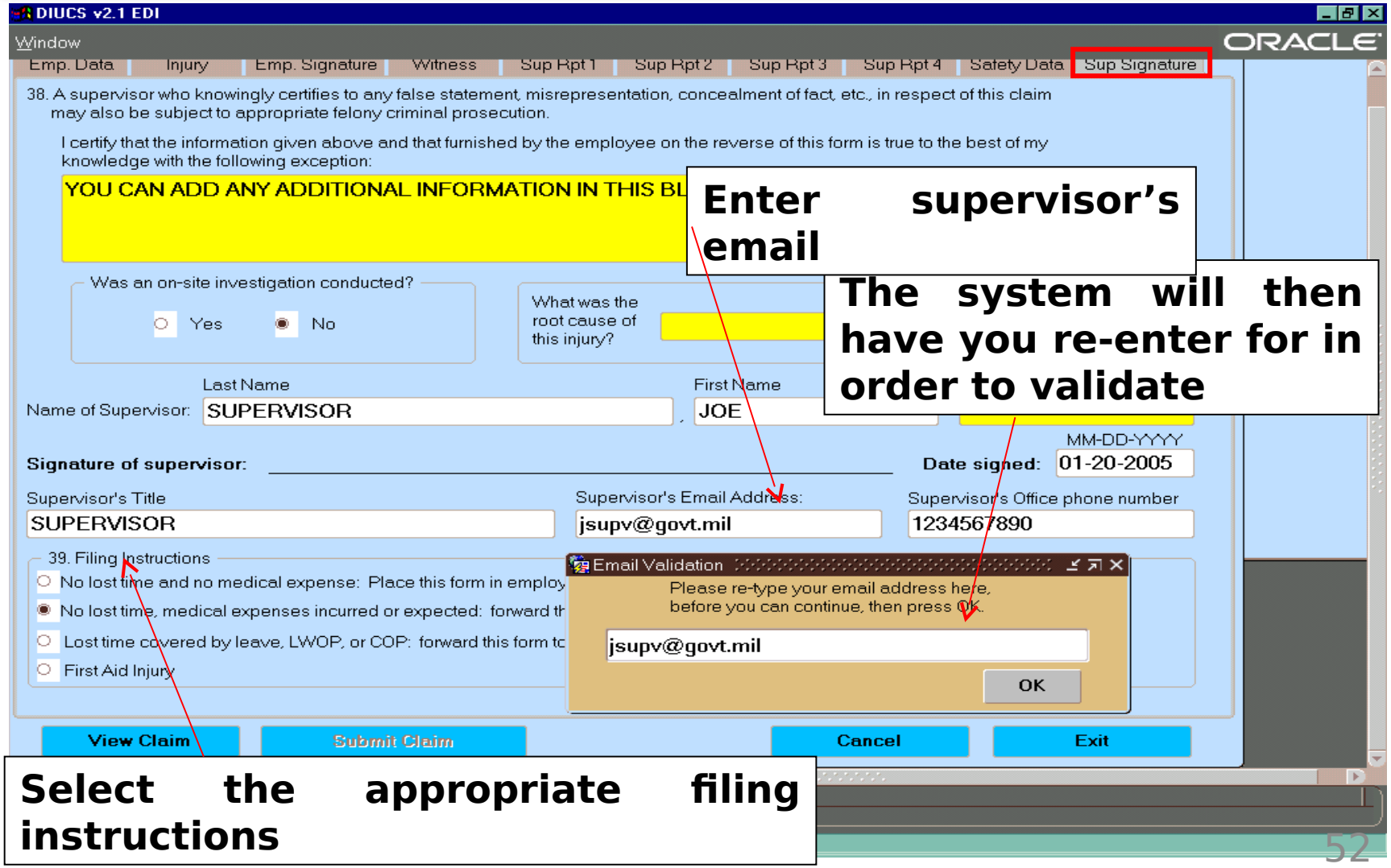
# Office of Workers Compensation Program




**Using CTRL+L when the cursor is placed in the Privacy Case Status field will display the listing of values for that field**

**Check all that apply for the sections on this tab. Information will be used to generate the OSHA 301 notice used for safety notification**

# Office of Workers Compensation Program

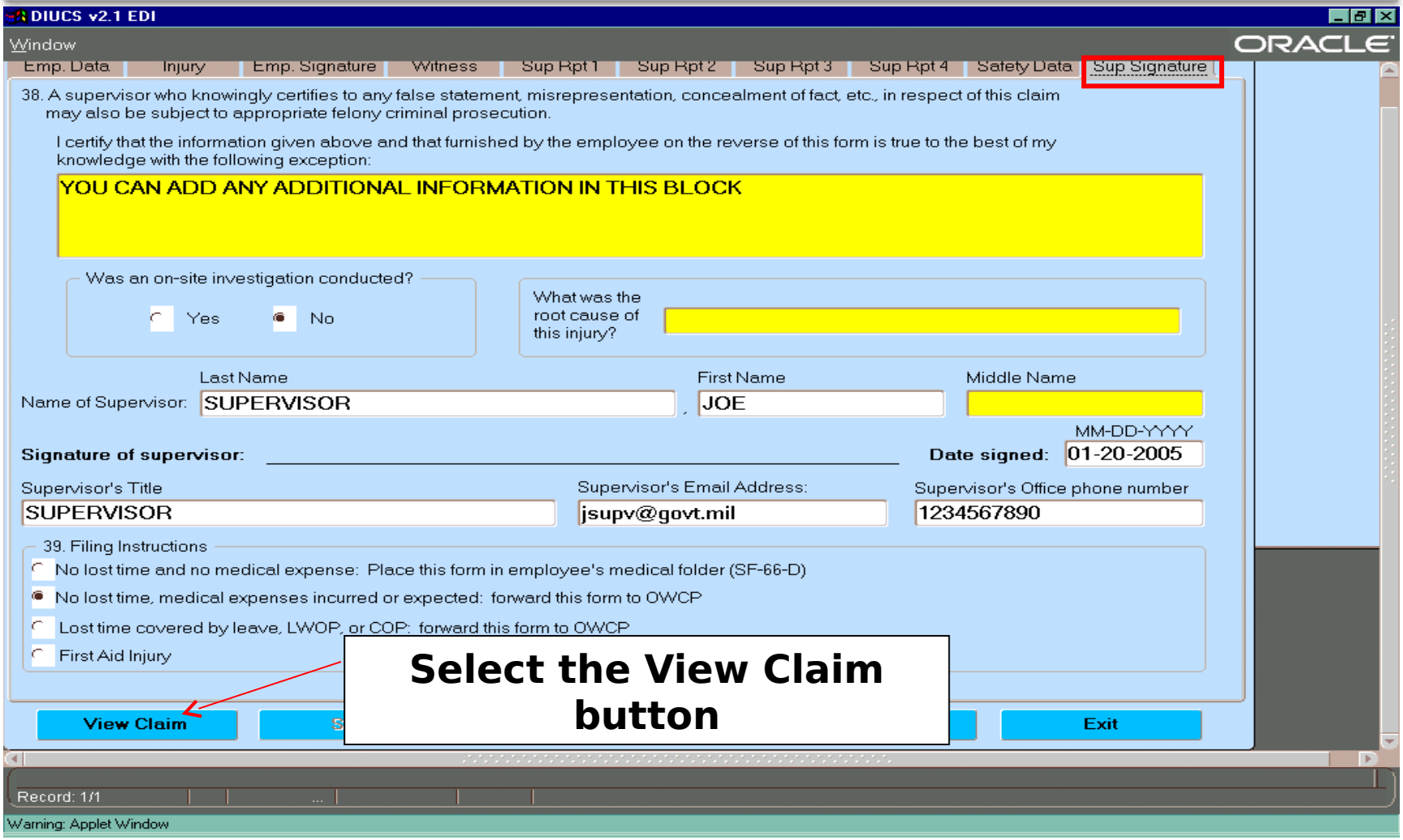



**Enter supervisor's email**

**The system will then have you re-enter for in order to validate**

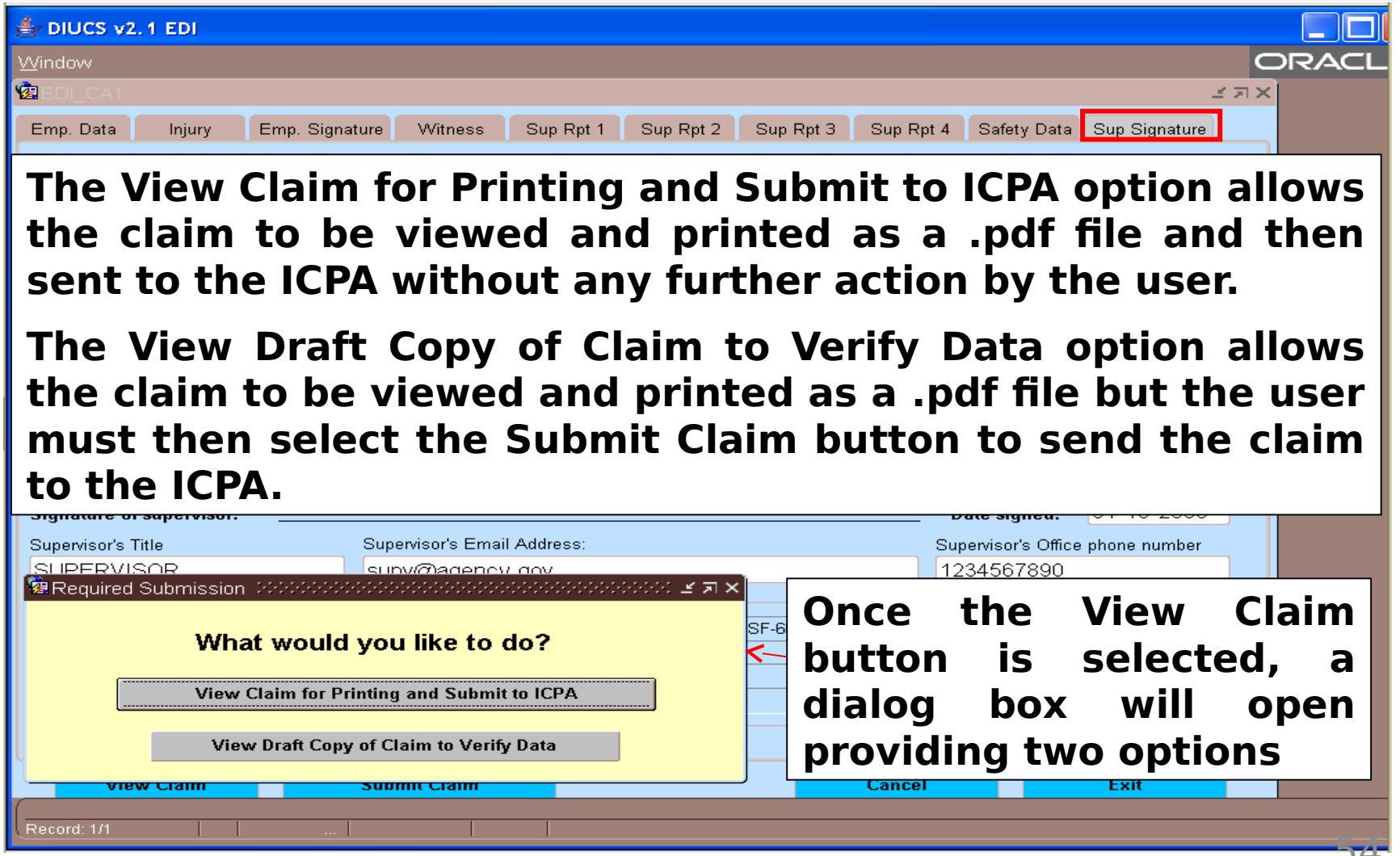
**Select the appropriate filing instructions**

# Office of Workers Compensation Program




**Select the View Claim button**

# Office of Workers Compensation Program

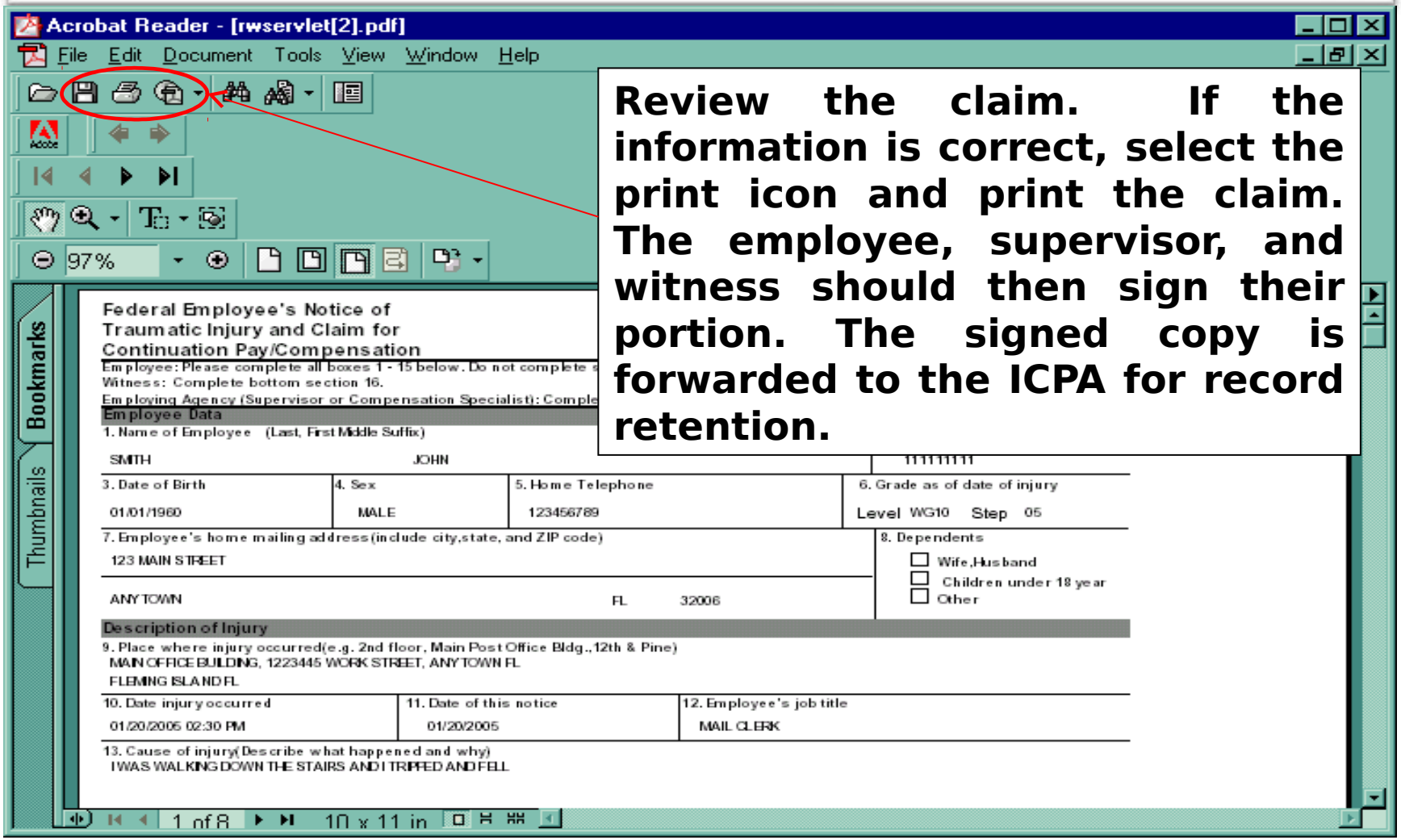



**The View Claim for Printing and Submit to ICPA option allows the claim to be viewed and printed as a .pdf file and then sent to the ICPA without any further action by the user.**

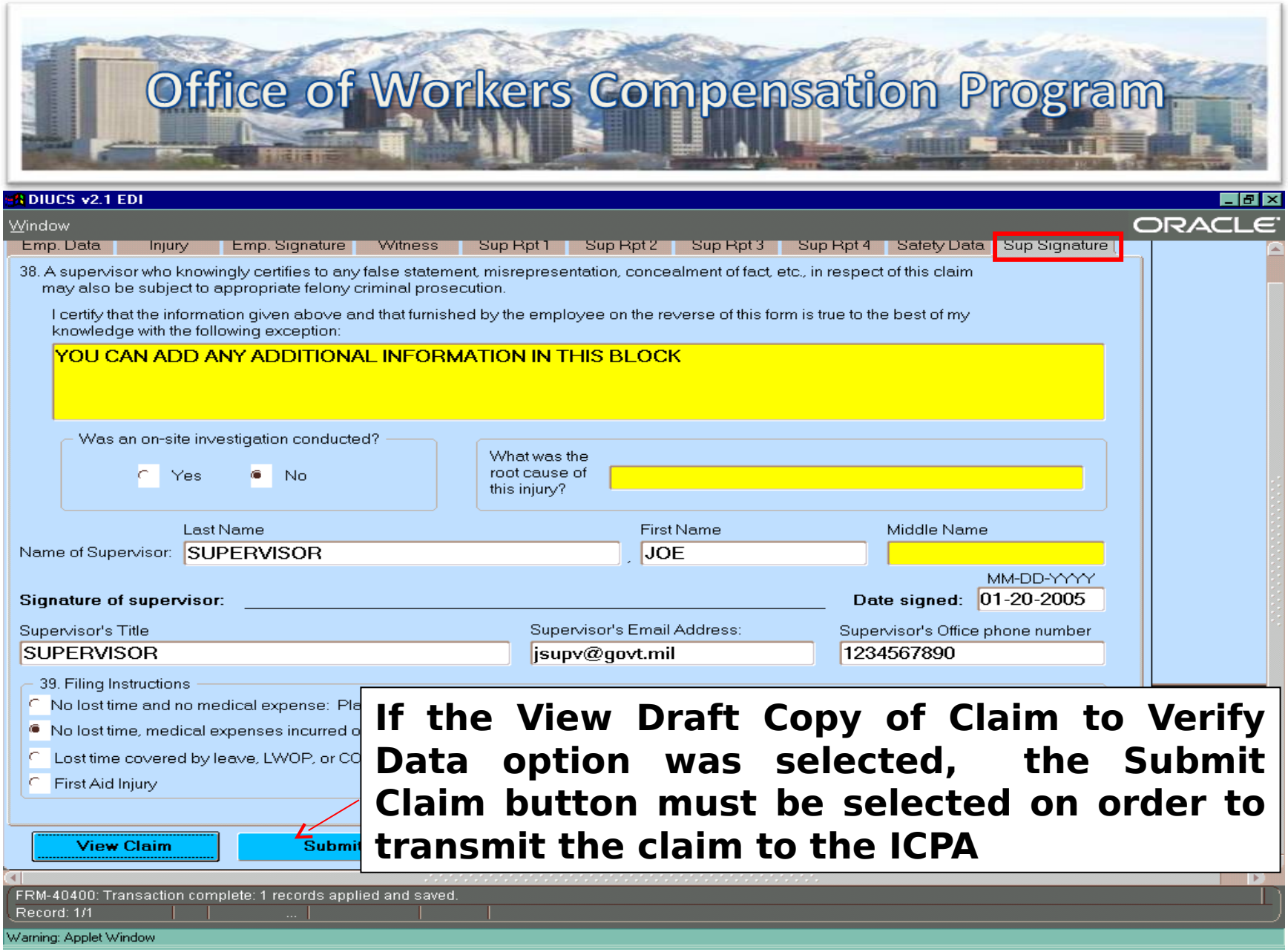
**The View Draft Copy of Claim to Verify Data option allows the claim to be viewed and printed as a .pdf file but the user must then select the Submit Claim button to send the claim to the ICPA.**

**Once the View Claim button is selected, a dialog box will open providing two options**

# Office of Workers Compensation Program




**Review the claim. If the information is correct, select the print icon and print the claim. The employee, supervisor, and witness should then sign their portion. The signed copy is forwarded to the ICPA for record retention.**


Office of Workers Compensation Program
DIUCS v2.1 EDI
Window
ORACLE
Emp. Data
Injury
Emp. Signature
Witness
Sup Rpt 1
Sup Rpt 2
Sup Rpt 3
Sup Rpt 4
Safety Data
Sup Signature
38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.
I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:
YOU CAN ADD ANY ADDITIONAL INFORMATION IN THIS BLOCK
Was an on-site investigation conducted?
Yes
No
What was the root cause of this injury?
Last Name
First Name
Middle Name
Name of Supervisor:
SUPERVISOR
JOE
MM-DD-YYYY
Signature of supervisor:
Date signed:
01-20-2005
Supervisor's Title
Supervisor's Email Address:
Supervisor's Office phone number
SUPERVISOR
jsupv@govt.mil
1234567890
39. Filing Instructions
No lost time and no medical expense: Pla
No lost time, medical expenses incurred o
Lost time covered by leave, LWOP, or CO
First Aid Injury
View Claim
Submi
If the View Draft Copy of Claim to Verify Data option was selected, the Submit Claim button must be selected on order to transmit the claim to the ICPA
FRM-40400: Transaction complete: 1 records applied and saved.
Record: 1/1
Warning: Applet Window


# SUMMARY OF SUPERVISOR ACTIONS IN COMPLETING CA1

- Supervisor accesses the EDI application through the “Filing Claims Electronically” link on the ICUC Web page
- Supervisor enters the SSN and Date of Birth of the employee and selects whether a CA-1 or CA-2 will be filed
- Employee information is entered onto the form
- Witness information is entered (if applicable)
- Supervisor enters required information in supervisors portion of the form
- The form is printed
- The employee, witness and supervisor sign their respective sections
- “Submit Claim” button is selected and claim is sent electronically to the ICPA
- Signed claim form is sent to the ICPA to be retained in the file


# TIMELINESS

Federal agencies are required by regulation to submit an employee's Notice of Injury (Form CA-1 or CA-2) CA-16, CA-17 and all supporting documentation within 10 working days (or 14 calendar days) of receiving notice of injury from an employee. Supervisor will ensure the following documentation is complete and sent to IPCA Coordinator for further processing.


# Required documentation that must be sent to the IPCA

- CA-1 Federal Employee's Notice of Traumatic Injury and Claim for Continuation Pay/Compensation
  - ✓Ensure block 15 is signed by employee or person acting on his/her behalf
  - ✓Ensure block 16 is signed if there was a witness statement
  - ✓Supervisor will sign block 38
- CA-16 Authorization for Examination And/Or Treatment
  - ✓Supervisor must complete block 8&9
  - ✓Block 35 must be signed by a Medical Doctor (MD)


# Required documentation that must be sent to the IPCA

- CA-17 Duty Status Report
  - ✓Block 19 must be signed by a Medical Doctor (MD)
  - ✓CA-17 informs the Supervisor of any limitations the employee may have and if the employee is to be placed on light duty or Continuation of Pay (COP)

- And any other supporting documentation received from Medical Provider

**REMINDER**

Only a Medical Doctor (M.D.) signature is acceptable on all medical documents


# Supervisor OWCP Checklist

# See Handout


# Continuation of Pay (COP)

COP is payable for a maximum of 45 calendar days

Employee was injured on November 1 and was coded LU and returned to work on November 2. Medical Provider stated on CA-16 and CA-17 that the employee follow-up November 6. Medical Provider restricted employee from returning to work until November 8 and on November 9 employee was returned to work with no restrictions.


| Sun | Mon | Tue | Wed | Thu | Fri | Sat |
|---|---|---|---|---|---|---|
| **NOVEMBER** | | | 1 Date of Injury Admin Leave | 2 COP CAN BEGIN CODE LT | 3 | 4 |
| 5 | 6 Code LT | 7 Code LT | 8 Code LU Code LT | 9 | 10 | 11 |
| 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| 19 | 20 | 21 | 22 | 23 | 24 | 25 |
| 26 | 27 | 28 | 29 | 30 | | |


| Sun | Mon | Tue | Wed | Thu | Fri | Sat |
|---|---|---|---|---|---|---|
| **DECEMBER** | | | | | 1 | 2 |
| 3 | 4 | 5 | 6 | 7 | 8 | 91 |
| 10 | 11 | 12 | 13 | 14 | 15 | **45 Day** 16 |
| 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| 24<br>31 | 25 | 26 | 27 | 28 | 29 | 30 |


# Continuation of Pay (COP)

# See Handout

# LIGHT DUTY

## Responsibility of…

- the supervisor to try to accommodate the return of an employee on light duty
- the HRO to officially reassign an employee to another position if necessary
- the employee to cooperate


# LIGHT DUTY POLICY

Placing Technicians on Light Duty (TN-11-02) as per the direction of NGB

**See Handout**


# LIGHT DUTY POLICY MEMORANDUM

# See Handout


# Physical Fitness Agreement

## See Handout


# QUESTIONS
# &
# ANSWERS